UNION COUNTY VOCATIONAL - TECHNICAL SCHOOLS

1776 Raritan Road, Scotch Plains, New Jersey 07076-2997
(908) 889-8288 Ext. 405 Fax: (908) 889-1599 www.ucvts.org
Nurse's Office

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

BOTH PAGES OF THIS FORM MUST BE COMPLETED

Asthma Inhalers_____ Allergic Reaction Kit _____

Student's Name (please print) _____

*Date of Birth*_____ *School (please circle one) AAHS AIT APA MHS UCT*

To be completed by physician (Please Print)

I am requesting that the above named student be allowed to carry and self-administer the following medication(s):

Indicated Diagnosis: _____
Name of Medication: _____
Prescribed Dosage: _____
If Daily, at what time: _____
If PRN, describe indications and how soon medication can be repeated if needed:
_____

Possible side effects and/or special precautions to be taken: _____
_____

Expiration date (if any) of prescription: _____

Conditions under which self-administration will take place:

_____ *Independently: Student has been trained and is proficient in self-administering medication and is aware that he/she may not share the medication with anyone else. Medication should be kept with student.*

_____ *Under supervision of school nurse (medication will be kept in school nurse's office)*

_____ _____
Physician's Name (stamp) Physician's signature

_____ _____
Phone Number Date

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Parental Request for Self-Administration of Medication

I give permission for my child (please print name)_____, to carry and self-administer the medication prescribed on page one, while on school property or at an approved school event off campus. I will notify the school nurse if this medication is no longer required or if self-administration is no longer directed by the physician.

The medication is to be provided by me (parent/guardian) in the original labeled container. **A duplicate of this medication is to be sent and kept in the nurse's office.** To my knowledge, my child is not allergic to the medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants, and representatives from administration of this medication.

_____ _____
Parent/Guardian Signature Date

Medication Contract

_____ _____
Name of Medication ***Date***

I understand that I will use this medication as directed by my physician. I should have the medication readily accessible, and I will be responsible and discreet about using it.

I have been instructed by Dr. _____(please print) on how to self-administer this medication and understand the side effects of improper use. This medication must be carried in the original labeled pharmacy container and may not be shared with anone else. **After each use, I will notify the school nurse.**

I understand that if I do not abide by the regulations, I may forfeit my right to carry and self-administer this medication. I understand this contract is to be renewed annually at the beginning of the school year.

_____ _____
Student Signature Parent/Guardian Signature